

09020

## CERTIFICATE OF DEATH

09028

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY X 2</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>LOTTIE</u> Middle <u>M. BRADFORD</u> Last <u>BRADFORD</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>17</u> Year <u>1957</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 18, 1877</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>NEWARK MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN SMITH</u>		14. MOTHER'S MAIDEN NAME <u>AMANDA JACKSON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>MR. HARRY A. BRADFORD</u>		Address <u>OCEAN CITY MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>593 x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio sclerosis</u> DUE TO (c) <u>Chr. Brights</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 10, 1957</u> , to <u>Aug 17, 1957</u> , that I last saw the deceased alive on <u>Aug 17, 1957</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) <u>Berlin Md</u>		DATE SIGNED <u>Aug 10-57</u>	
ACTUAL SIGNATURE <u>Chas. P. Law</u>		M.D. <u>Berlin Md</u>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8/20/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>	22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Bunby</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>Aug 22 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Helen F. [Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

20030

PLACE TO BE FILLED

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

NAME OF SPOUSE

DATE OF INTERMENT

NAME OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF URN

NAME OF CASK

NAME OF COFFIN

NAME OF CASKET

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BUREAU V. B.

AUG 22 1957

RECEIVED

09021

CERTIFICATE OF DEATH

09029

Reg. Dist. No.

357

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OCEAN CITY</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>WILLIAM THOMAS BURBAGE</b>				4. DATE OF DEATH <b>AUG. 6 1957</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 14 1881</b>	
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED COAST GUARD</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>GOVERNMENT</b>		11. BIRTHPLACE (State or foreign country) <b>BERLIN MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES BURBAGE</b>				14. MOTHER'S MAIDEN NAME <b>FANNY GARDNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>WORLD WAR</b>		17. INFORMANT <b>MR. LUTHER BURBAGE, SALISBURY MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Complete Heart Block</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Coronary Sclerosis</b> (c) <b></b>				INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>2 yrs.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1956</b> to <b>6 Aug. 1957</b> , that I last saw the deceased alive on <b>6 Aug. 1957</b> , and that death occurred at <b>10:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. H. Thomas</b>				ADDRESS (Street, city or town, state) <b>Pharmac &amp; med st</b> DATE SIGNED <b>7 Aug 57</b>			
PHYSICIAN'S NAME (Type) <b>N. R. Thomas</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/8/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		22d. LOCATION (City, town, or county) (State) <b>BERLIN MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna D. Burbage</b> ADDRESS <b>Berlin Md</b>				24a. REC'D BY REGISTRAR <b>AUG 9 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Kelen</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DATE OF DEATH

PLACE HERE THE SIGNATURE OF THE REGISTRAR

DATE

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BUREAU V. 3

JUG 9 1957

RECEIVED

09022

## CERTIFICATE OF DEATH

Reg. Dist. No.

351

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark #1</u>				c. LENGTH OF STAY IN 1b <u>78 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Newark #1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Clara M. Leher</u>				4. DATE OF DEATH <u>August 14 1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 21-1881</u>	
9. AGE (In years last birthday) <u>76 9/23</u>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Snow Hill, md</u>		12. CITIZEN OF WHAT COUNTRY? <u>md</u>	
13. FATHER'S NAME <u>Edward J. Maddox</u>				14. MOTHER'S MAIDEN NAME <u>Mary Gausey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Mrs. Reg. F. Leher</u>				Address <u>Snow Hill, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia &amp; Inanition</u> DUE TO <u>446X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Malignant Nephrosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u> <u>10 mos.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb 1 1957</u> to <u>Aug 14 1957</u> , that I last saw the deceased alive on <u>Aug 13 1957</u> , and that death occurred at <u>1:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>104 Bay St Snow Hill, Md.</u> DATE SIGNED <u>8-15-57</u>							
ACTUAL SIGNATURE <u>Robert C. La Mar</u> M.D.				PHYSICIAN'S NAME (Type) <u>ROBERT C. LA MAR, M.D.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial Aug 16/57</u>		<u>Aug 16/57</u>		<u>Bates Mithroft</u>		<u>Snow Hill md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter B. Simms</u> ADDRESS <u>Snow Hill, md</u>				24a. REC'D BY REGISTRAR <u>AUG 19 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Elwyn Cooper</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed with the hospital or attending physician.

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CERTIFICATE OF DEATH

00035

Georgie A. Inman  
Mellin's Food

BUREAU V. 3

AUG 19 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>3 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 BERLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>BROAD ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEPHEN JOSEPH DARDEN</u>				4. DATE OF DEATH Month Day Year <u>AUG. 29 1957</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR. 20, 1896</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EXPRESS AGENT RET.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FRUIT GROWERS</u>		11. BIRTHPLACE (State or foreign country) <u>CLINTON N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HENRY K. DARDEN</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE KING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u>		16. SOCIAL SECURITY NO. <u>WORLDWARI</u>		17. INFORMANT <u>MRS. S. S. DARDEN</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>156.1</u> DUE TO <u>Hepatic Coma and failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>malignancy of liver</u> DUE TO (c) <u>2 days.</u> <u>2 months</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Thrombosis 3 years ago.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>November 1954</u> to <u>August 1957</u> , that I last saw the deceased alive on <u>August 29, 1957</u> , and that death occurred at <u>3:00 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Grubb MD</u> M.D.				ADDRESS (Street, city or town, state) <u>BERLIN, MD.</u>		DATE SIGNED <u>8-30-57</u>	
PHYSICIAN'S NAME (Type) <u>ROBERT A. GRUBB, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/31/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>		22d. LOCATION (City, town, or county) (State) <u>BERLIN MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Buboye Berlin and</u>				ADDRESS <u>SEP 4 1957</u>		24a. REC'D BY REGISTRAR <u>Robert F. Hayward</u>	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

SEP 4 1957

BUREAU V. 2

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09024

## CERTIFICATE OF DEATH

09032

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Ocean City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>West Ocean City</b> x2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Old State Rd.</b>			
3. NAME OF DECEASED (Type or print) <b>Annie Cooper Davis</b>				4. DATE OF DEATH Month <b>8</b> Day <b>16</b> Year <b>1957</b>			
5. SEX <b>F. M.</b>		6. COLOR OR RACE <b>AA</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 17, 1910</b>	
9. AGE (In years last birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Charles Bryant</b>				14. MOTHER'S MAIDEN NAME <b>Rachel ? Bryant</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>none</b>		17. INFORMANT Address <b>Mr. James Davis, West Ocean City, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma</b> <b>170x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of breast</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>1 yr 2 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. ft. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March, 1957</b> , to <b>16 Aug, 1957</b> , that I last saw the deceased alive on <b>14 Aug, 1957</b> , and that death occurred at <b>9:10 A. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>J. F. Stewart</b>				ADDRESS (Street, city or town, state) <b>19 Aug 57</b>			
PHYSICIAN'S NAME (Type) <b>W. R. Thomas</b>				DATE SIGNED <b>Oct 21, 1957</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-18-1957</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Berlin, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. F. Stewart Funeral Home, Salisbury, Md</b>				24. REC'D BY REGISTRAR DATE <b>10 21 1957</b>			
				24b. REGISTRAR'S SIGNATURE <b>John F. Hayward</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Name of Deceased		Date of Death		Place of Death	
John Doe		1957		Baltimore, MD	
Age		Sex		Race	
45		Male		White	
Date of Birth		Place of Birth		Cause of Death	
1912		Maryland		Heart Disease	
Occupation		Marital Status		Signature of Physician	
Teacher		Married		[Signature]	
Signature of Informant		Relationship to Deceased		Date of Report	
[Signature]		Wife		1957	

BUREAU V. 2

AUG 21 1957

RECEIVED

09025

## CERTIFICATE OF DEATH

Reg. Dist. No.

353

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Bishop, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X/Bishop Rural</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Charles Edward Fassett</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>1</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1891</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clay Fassett</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT <u>James Fassett</u>		Address <u>Bishop, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular disease</u> DUE TO (c) <u>3 yrs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>July 7, 1957</u> , to <u>July 13, 1957</u> , that I lost the deceased on <u>July 17, 1957</u> , and that death occurred at <u>7/10/57</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Berlin Md</u>			
PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr., M.D.</u>				DATE SIGNED <u>8/2/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 4, 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Sarah Dukes</u>		22d. LOCATION (City, town, or county) (State) <u>Bishop, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry W. Watson</u>				ADDRESS <u>Pocomoke City, Md.</u>		24b. REC'D BY REGISTRAR <u>AUG 6 1957</u>	
				24c. REGISTRAR'S SIGNATURE <u>Alfred R. Lacey</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

09017

## CERTIFICATE OF DEATH

Reg. Dist. No.

09034  
350

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City 43</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>401 Linden Ave.</b>				d. STREET ADDRESS <b>401 Linden Ave.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <b>Sophronia F. Gillette</b>				4. DATE OF DEATH Month <b>August</b> Day <b>28</b> Year <b>19 57</b>			
5. SEX <b>F.</b>		6. COLOR OR RACE <b>C.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Jan. 26, 1878</b>	
9. AGE (In years last birthday) <b>79</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William Lane</b>				14. MOTHER'S MAIDEN NAME <b>Maria Waters</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>213-05-2096</b>		17. INFORMANT <b>401 Linden Ave.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration &amp; gastric Carcinoma Exhaustion</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>gastric Carcinoma</b> DUE TO (c) <b>Ca of Colon</b>				INTERVAL BETWEEN ONSET AND DEATH <b>6 mths</b> <b>6 mths</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Ca of Colon</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/3/55</b> , 19 <b>55</b> , to <b>8/28/57</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8/27/57</b> , 19 <b>57</b> , and that death occurred at <b>2:30 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Cecil A. Duverney</b> M.D.				ADDRESS (Street, city or town, state) <b>801 - 4th St, Pocomoke</b> DATE SIGNED <b>8/29/57</b>			
PHYSICIAN'S NAME (Type) <b>Cecil A. Duverney, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/31/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Halls Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgar Wharton - new church Va</b>				24a. REC'D BY REGISTRAR DATE <b>9/3/57</b>		24b. REGISTRAR'S SIGNATURE <b>Anne E. White</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be registered by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>10-15-57</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Teacher</i>		11. MARITAL STATUS <i>Married</i>		12. EDUCATION <i>High School</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. MEDICAL HISTORY <i>None</i>		15. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>	
16. SIGNATURE OF DECEASED <i>John Doe</i>		17. SIGNATURE OF WITNESSES <i>John Doe, Jane Doe</i>		18. SIGNATURE OF REGISTRAR <i>John Doe</i>	

BUREAU V. 2

SEP 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09018

## CERTIFICATE OF DEATH

Reg. Dist. No.

09035

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>42 Pocomoke</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Home</u>				d. STREET ADDRESS <u>1 515 Laurel St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>HAYES</u> Last <u>HAYES</u>				4. DATE OF DEATH Month <u>August</u> Day <u>31</u> Year <u>1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>col.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 26, 1886</u> 70 yrs.	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>mining</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>233-14-0968</u>		17. INFORMANT <u>Fred Hayes - 515 Laurel St. Pocomoke</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Exhaustion &amp; Dehydration</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cancer of Prostate</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks.</u> <u>4 mths.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASCD &amp; Congestive Heart Failure</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>12/57</u> , 19 <u>57</u> , to <u>8/30/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>8/30/57</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Cecil A. Duverney</u> M.D.				ADDRESS (Street, city or town, state) <u>801 - 4th St, Pocomoke</u> DATE SIGNED <u>8/31/57</u>			
PHYSICIAN'S NAME (Type) <u>Cecil A. Duverney, M. D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 4 1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Pocomoke Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>9/3/57</u>		24b. REGISTRAR'S SIGNATURE <u>Anne E. Sheto</u>	

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and signature. The form is mostly blank with some faint, illegible markings.

BUREAU V. 3

SEP 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 09036									
1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore City</u>				
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Ocean City</u>			c. LENGTH OF STAY IN 1b <u>1 week</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			# <u>153</u> Vol. <u>4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>34th &amp; Philadelphia Ave</u>					d. STREET ADDRESS <u>3820 BARRINGTON RD</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MRS Elsie MARY Holden</u>					4. DATE OF DEATH <u>August 8 1957</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAR 3 1889</u>		9. AGE (In years last birthday) <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Adam Osterman</u>					14. MOTHER'S MAIDEN NAME <u>Barbara Boh</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>MRS David A. Williams (sister)</u>		Address <u>Broadview Apts Baltimore, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic CVD</u> DUE TO (c) <u>44 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Entombment</u>		22b. DATE THEREOF <u>8/12/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Mausoleum</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ellsworth Armacost</u>					24a. REC'D BY REGISTRAR <u>AUG 12 1957</u>		24b. REGISTRAR'S SIGNATURE <u>John F. Hayward</u>		

Handwritten text on the form includes:  
Name: [illegible]  
Age: [illegible]  
Sex: [illegible]  
Date of Birth: [illegible]  
Date of Death: [illegible]  
Cause of Death: [illegible]  
Place of Death: [illegible]  
Signature: [illegible]

**RECEIVED**  
AUG 12 1957  
BUREAU V. S.

*Handwritten signature*



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

VS. A15ME(5)  
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 9 Film 6219 8-20-57 et

Reg. Dist. No.

090371

1. PLACE OF DEATH a. COUNTY <i>Worcester County</i>		2. USUAL RESIDENCE (where deceased lived. If institution: Residence before admission) a. STATE <i>Georgia</i> b. COUNTY <i>Macon</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Snow Hill</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Macon</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>D.K.</i>	
3. NAME OF DECEASED (Type or print) <i>Daniel Mathews</i>		4. DATE OF DEATH <i>Aug 9th 1957</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>D.K. Approx. 38 yrs.</i>
9. AGE (In yrs. last birthday) <i>38</i>		10. IF UNDER 1 YEAR Months Days 11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Agriculture</i>	
11. BIRTHPLACE (State or foreign country) <i>Dont know</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>No record available</i>		14. MOTHER'S MAIDEN NAME <i>No record available</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>Unknown</i>		16. SOCIAL SECURITY NO. <i>(7)</i>	
17. INFORMANT <i>Snow Hill Police Dept.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>850x</i> DUE TO <i>Drowning</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Flow in water</i> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <input checked="" type="checkbox"/>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>Fall between boat and shore under water</i>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <i>Worce.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>N.E. Sartorius</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>N.E. Sartorius</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Aug 11/57</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>County Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Snow Hill Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomas F. Manning</i>		ADDRESS <i>Snow Hill</i>	
24a. REC'D BY REGISTRAR <i>Aug 15 1957</i>		24b. REGISTRAR'S SIGNATURE <i>Charles Cooper</i>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2.

AUG 15 1957

RECEIVED

9028

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Worcestershire</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City Md</u>				c. LENGTH OF STAY IN 1b <u>2 Mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>Delaware</u>			
3. NAME OF DECEASED (Type or print) <u>SURUSHA</u> First <u>MAV</u> Middle <u>MCCABE</u> Last				4. DATE OF DEATH <u>Aug.</u> Month <u>17</u> Day <u>1957</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug 23 1878</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>		11. BIRTHPLACE (State or foreign country) <u>Delaware</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joshua Evans</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Vance McCabe</u> Address <u>Frankford Dela.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>Cardiac Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Jun 55</u> , 19 <u>55</u> , to <u>Aug</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Aug 1</u> , 19 <u>57</u> , and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>William R. Connelley</u> M.D. <u>Brathany Beach</u> ADDRESS (Street, city or town, state)				DATE SIGNED <u>Aug 18 1957</u>			
PHYSICIAN'S NAME (Type) <u>William R. Connelley</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/20/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosana M.C.</u>		22d. LOCATION (City, town, or county) (State) <u>Rosana Delaware</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Watson &amp; Gray</u> ADDRESS <u>Frankford Dela.</u>				24a. REC'D BY REGISTRAR <u>AUG 26 1957</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Robert P. Haywood</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shows, be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

200-210-100

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
LAST, FIRST, MIDDLE		M		25		JAN 1 1932		BALTIMORE, MARYLAND	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION		DECEASED'S OCCUPATION	
JOHN DOE		JANE DOE		Carpenter		Homemaker		Student	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH	
HEART DISEASE		NATURAL		HOME		JUL 15 1957		10:30 AM	
PREVIOUS ILLNESS		PREVIOUS SURGERY		PREVIOUS TRAUMA		PREVIOUS DRUGS		PREVIOUS ALCOHOL	
NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF DECEASED		SIGNATURE OF NEXT OF KIN	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
DATE		TIME		PLACE		DATE		TIME	
JUL 15 1957		10:30 AM		HOME		JUL 15 1957		10:30 AM	

RECEIVED  
AUG 26 1957  
BUREAU V. 8

09019

## CERTIFICATE OF DEATH

Reg. Dist. No.

350

1. PLACE OF DEATH a. COUNTY <b>Worcester</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke City</b>			c. LENGTH OF STAY IN 1b <b>47 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>42 Pocomoke City</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>508 Clarke Avenue</b>				d. STREET ADDRESS <b>508 Clarke Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>Mae</b> Last <b>McDaniel</b>				4. DATE OF DEATH Month <b>August</b> Day <b>21</b> Year <b>19 57</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17, 1885</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John W. Cutler</b>				14. MOTHER'S MAIDEN NAME <b>Sarah D. Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Linwood McDaniel, Pocomoke, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Degenerative Heart Disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>few minutes</b> <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>June 21, 1957</b> to <b>August 21, 1957</b> that I last saw the deceased alive on <b>June 21, 1957</b> , and that death occurred at <b>130 a. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Charles W. Trader</b> M.D.				ADDRESS (Street, city or town, state) <b>Pocomoke City, Md.</b>			
PHYSICIAN'S NAME (Type) <b>Charles W. Trader</b>				DATE SIGNED <b>8-22-57</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-23-57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Pocomoke City, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Henry D. Watson</b>				ADDRESS <b>Pocomoke, Md.</b>		24a. REC'D BY REGISTRAR <b>AUG 26 1957</b>	
				24b. REGISTRAR'S SIGNATURE <b>Lane H. Hester</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

9029

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OCEAN CITY</u>				c. LENGTH OF STAY IN 1b <u>4 YRS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 OCEAN CITY</u>			
d. STREET ADDRESS <u>1 DOLPHIN ST.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JOHN FREDERICK MEYER</u>				4. DATE OF DEATH Month Day Year <u>AUG. 2 1957</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 1, 1872</u>	
9. AGE (In years last birthday) <u>85 YRS.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT (RETIRED) OWN BUSINESS</u>				11. BIRTHPLACE (State or foreign country) <u>BREMEN, GERMANY</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John D. Meyer</u>				14. MOTHER'S MAIDEN NAME <u>Friedericke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>216-03-7230</u>			
17. INFORMANT <u>Mrs. J. F. Meyer</u>				Address <u>OCEAN CITY MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>951x Homologous Serum Jaundice</u> DUE TO <u>Blood transfusion (?)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic C.-v.-renal disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1955</u> to <u>2 Aug. 1957</u> , that I last saw the deceased alive on <u>2 Aug. 1957</u> , and that death occurred at <u>11:55 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Pleasant Mount, Worcester, Md.</u> DATE SIGNED <u>3 Aug. 57</u>							
ACTUAL SIGNATURE <u>J. D. Thomas</u> M.D. <u>Phlebotomist, Ocean City, Md.</u>							
PHYSICIAN'S NAME (Type) <u>J. D. Thomas</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8/6/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna D. Burbey</u> ADDRESS <u>Berlin Md</u>				24a. REC'D BY REGISTRAR <u>AUG 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Helen Hayward</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13, 14: 70 only 8/6/57 GE (b, 12) see app #70, Damour, back.

CERTIFICATE OF DEATH

RECEIVED  
AUG 6 1957  
BUREAU V. S.

9030

## CERTIFICATE OF DEATH

Reg. Dist. No.

355

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>WORCESTER</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>GEORGE EWELL PARSONS</b>		4. DATE OF DEATH <b>AUG 30 1957</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAR. 31, 1871</b>
9. AGE (In years lost birthday) <b>86 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>	
11. BIRTHPLACE (State or foreign country) <b>BERLIN MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S. IT</b>	
13. FATHER'S NAME <b>Marion Parsons</b>		14. MOTHER'S MAIDEN NAME <b>Betta Middleton</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>	
17. INFORMANT <b>MR. ELWOOD PARSONS</b>		Address <b>BERLIN MD</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Nephritis</b> <b>191X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cancer of esophagus</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>May 4 - 1957</b> , to <b>Aug 30 - 1957</b> , that I last saw the deceased alive on <b>Aug 30 - 1957</b> , and that death occurred at <b>4:10 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Chas R Law</b> M.D.		ADDRESS (Street, city or town, state) <b>Berlin Md</b> DATE SIGNED <b>Aug 31-57</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>9/2/57</b>	22c. NAME OF CEMETERY OR CREMATORY <b>TAYLORVILLE</b>	22d. LOCATION (City, town, or county) (State) <b>BERLIN MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Anna A. Burbage</b> ADDRESS <b>Berlin Md</b>		24a. REC'D BY REGISTRAR <b>SEP 4 1957</b> 24b. REGISTRAR'S SIGNATURE <b>Helen Hayward</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

PORTLAND STATE DEPARTMENT OF HEALTH - BUREAU 18

SEP 4 1957

BUREAU V. 8

SEP 4 1957

RECEIVED



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
9031 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09042

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN 1b <u>5 Hours</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Beach at Dorchester St.</u>	
d. STREET ADDRESS <u>3823 Rexwre Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
4. DATE OF DEATH First <u>John</u> Middle <u>Popp Jr</u> Last <u>Aug</u> Month <u>4</u> Day <u>19</u> Year <u>57</u>		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Feb 14 1912</u> 9. AGE (In years last birthday) <u>45</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Newspaper</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Popp</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Beale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>3823 Rexwre Rd</u>	
17. INFORMANT <u>Mrs Medred Popp (wife)</u>		Address <u>Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion acute</u> 260X DUE TO <u>Arteriosclerotic C.V.D.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>2 years</u>		INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT.</u> <u>2 years</u> <u>2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Francis J. Townsend Jr</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>FRANCIS J. TOWNSEND JR</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>Aug 4, 1957.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>8-7-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna H. Burby</u>		ADDRESS <u>Berlin Md</u>	
24a. REC'D BY REGISTRAR <u>AUG 6 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Robert F. Haywood</u>	

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

AUG 6 1957

RECEIVED

9032

## CERTIFICATE OF DEATH

Reg. Dist. No. 351

1. PLACE OF DEATH o. COUNTY <u>Worcester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <u>md</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XO Snow Hill</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>113 Lundy St</u>				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Devis</u> First <u>Sue</u> Middle <u>Shackley</u> Last				4. DATE OF DEATH <u>August 31</u> Month <u>1957</u> Day Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jul 19-1954</u>	
9. AGE (In years last birthday) <u>3/4/13</u>		IF UNDER 1 YEAR Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, md</u>	
11. BIRTHPLACE (State or foreign country) <u>Salisbury, md</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Theodore Jenkins Jr</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Virginia Shackley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or not known) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT <u>Dorothy Virginia Shackley Smith, md</u>				Address <u>113 Lundy St</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Brain Tumor</u> <u>237X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>113 Lundy St</u> DUE TO (c) <u>6 mo</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 1957, to <u>8/30/57</u> 19, that I last saw the deceased alive on <u>8/30/57</u> , 19, and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Snow Hill Md.</u> DATE SIGNED <u>Paul Cohen</u> M.D.							
ACTUAL SIGNATURE <u>Paul Cohen</u> M.D. <u>Snow Hill Md.</u>							
PHYSICIAN'S NAME (Type) <u>Wag &amp; Morris</u>							
22a. MANNER OF DEATH (Specify) <u>Natural</u>		22b. DATE THEREOF <u>Sept 1/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>North Chapel</u>		22d. LOCATION (City, town, or county) (State) <u>Snow Hill, md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wag &amp; Morris</u>				24a. REC'D BY REGISTRAR <u>Snow Hill, md</u>		24b. REGISTRAR'S SIGNATURE <u>Chas Cooper</u>	
DATE <u>SEP 3 1957</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1957

BUREAU V. B.

SEP 3 1957

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11308

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## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Prince Georges Co</i>		STATE <i>Md</i>		COUNTY <i>Prince Georges</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Berlin</i>		<i>Life</i>		TOWN <i>Berlin</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
				<i>R.R. Ave</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
<i>Seamus Timmons</i>				<i>8 25 1957</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (If married, give date)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Male</i>	<i>Cel</i>	<i>Married</i>	<i>12-18-1867</i>	<i>89</i>	Months <i>8</i> Days <i>25</i>		Hours <i>—</i> Min. <i>—</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<i>Teacher</i>				<i>none</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				12. CITIZEN OF WHAT COUNTRY?			
<i>Seamus Timmons</i>				<i>U.S.A.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<i>no</i>				<i>none</i>		<i>Seamus Timmons</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A)				<i>Degenerative Heart Disease</i>			
ANTECEDENT CAUSE(S) DUE TO				<i>Arteriosclerosis</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5/9</i> , 19 <i>56</i> , to <i>8/17</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>8/17</i> , 19 <i>57</i> , and that death occurred at <i>4:30 P</i> .M., from the causes and on the date stated above.							
SIGNATURE <i>Seamus Timmons</i>				ADDRESS (Street, city, town, state) <i>Berlin Md</i>		DATE SIGNED <i>8/26/57</i>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<i>Burial</i>		<i>8-29-57</i>		<i>Evergreen Cem</i>		<i>Berlin Md</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>OCT 16 1957</i>		<i>Seamus Timmons</i>		<i>Seamus Timmons</i>		<i>Berlin Md</i>	



# CERTIFICATE OF DEATH

Local Date 1957

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE DATE

8. MARRIAGE PLACE

9. OCCUPATION

10. CAUSE OF DEATH

11. PLACE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESS

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CLERK

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF CORONER

20. SIGNATURE OF DECEASED

21. SIGNATURE OF WITNESS

22. SIGNATURE OF PHYSICIAN

23. SIGNATURE OF CLERK

24. SIGNATURE OF JUDGE

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF CORONER

27. SIGNATURE OF DECEASED

28. SIGNATURE OF WITNESS

29. SIGNATURE OF PHYSICIAN

30. SIGNATURE OF CLERK

31. SIGNATURE OF JUDGE

32. SIGNATURE OF SHERIFF

33. SIGNATURE OF CORONER

34. SIGNATURE OF DECEASED

35. SIGNATURE OF WITNESS

36. SIGNATURE OF PHYSICIAN

37. SIGNATURE OF CLERK

38. SIGNATURE OF JUDGE

39. SIGNATURE OF SHERIFF

40. SIGNATURE OF CORONER

41. SIGNATURE OF DECEASED

42. SIGNATURE OF WITNESS

43. SIGNATURE OF PHYSICIAN

44. SIGNATURE OF CLERK

45. SIGNATURE OF JUDGE

46. SIGNATURE OF SHERIFF

47. SIGNATURE OF CORONER

48. SIGNATURE OF DECEASED

49. SIGNATURE OF WITNESS

50. SIGNATURE OF PHYSICIAN

51. SIGNATURE OF CLERK

52. SIGNATURE OF JUDGE

53. SIGNATURE OF SHERIFF

54. SIGNATURE OF CORONER

55. SIGNATURE OF DECEASED

56. SIGNATURE OF WITNESS

57. SIGNATURE OF PHYSICIAN

58. SIGNATURE OF CLERK

59. SIGNATURE OF JUDGE

60. SIGNATURE OF SHERIFF

61. SIGNATURE OF CORONER

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64. SIGNATURE OF PHYSICIAN

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86. SIGNATURE OF CLERK

87. SIGNATURE OF JUDGE

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93. SIGNATURE OF CLERK

94. SIGNATURE OF JUDGE

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96. SIGNATURE OF CORONER

97. SIGNATURE OF DECEASED

98. SIGNATURE OF WITNESS

99. SIGNATURE OF PHYSICIAN

100. SIGNATURE OF CLERK

101. SIGNATURE OF JUDGE

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104. SIGNATURE OF DECEASED

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106. SIGNATURE OF PHYSICIAN

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109. SIGNATURE OF SHERIFF

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114. SIGNATURE OF CLERK

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134. SIGNATURE OF PHYSICIAN

135. SIGNATURE OF CLERK

136. SIGNATURE OF JUDGE

137. SIGNATURE OF SHERIFF

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141. SIGNATURE OF PHYSICIAN

142. SIGNATURE OF CLERK

143. SIGNATURE OF JUDGE

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145. SIGNATURE OF CORONER

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149. SIGNATURE OF CLERK

150. SIGNATURE OF JUDGE

151. SIGNATURE OF SHERIFF

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154. SIGNATURE OF WITNESS

155. SIGNATURE OF PHYSICIAN

156. SIGNATURE OF CLERK

157. SIGNATURE OF JUDGE

158. SIGNATURE OF SHERIFF

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163. SIGNATURE OF CLERK

164. SIGNATURE OF JUDGE

165. SIGNATURE OF SHERIFF

166. SIGNATURE OF CORONER

167. SIGNATURE OF DECEASED

168. SIGNATURE OF WITNESS

169. SIGNATURE OF PHYSICIAN

170. SIGNATURE OF CLERK

171. SIGNATURE OF JUDGE

172. SIGNATURE OF SHERIFF

173. SIGNATURE OF CORONER

174. SIGNATURE OF DECEASED

175. SIGNATURE OF WITNESS

176. SIGNATURE OF PHYSICIAN

177. SIGNATURE OF CLERK

178. SIGNATURE OF JUDGE

179. SIGNATURE OF SHERIFF

180. SIGNATURE OF CORONER

181. SIGNATURE OF DECEASED

182. SIGNATURE OF WITNESS

183. SIGNATURE OF PHYSICIAN

184. SIGNATURE OF CLERK

185. SIGNATURE OF JUDGE

186. SIGNATURE OF SHERIFF

187. SIGNATURE OF CORONER

188. SIGNATURE OF DECEASED

189. SIGNATURE OF WITNESS

190. SIGNATURE OF PHYSICIAN

191. SIGNATURE OF CLERK

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193. SIGNATURE OF SHERIFF

194. SIGNATURE OF CORONER

195. SIGNATURE OF DECEASED

196. SIGNATURE OF WITNESS

197. SIGNATURE OF PHYSICIAN

198. SIGNATURE OF CLERK

199. SIGNATURE OF JUDGE

200. SIGNATURE OF SHERIFF

201. SIGNATURE OF CORONER

202. SIGNATURE OF DECEASED

203. SIGNATURE OF WITNESS

204. SIGNATURE OF PHYSICIAN

205. SIGNATURE OF CLERK

206. SIGNATURE OF JUDGE

207. SIGNATURE OF SHERIFF

208. SIGNATURE OF CORONER

209. SIGNATURE OF DECEASED

210. SIGNATURE OF WITNESS

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213. SIGNATURE OF JUDGE

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220. SIGNATURE OF JUDGE

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234. SIGNATURE OF JUDGE

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237. SIGNATURE OF DECEASED

238. SIGNATURE OF WITNESS

239. SIGNATURE OF PHYSICIAN

240. SIGNATURE OF CLERK

241. SIGNATURE OF JUDGE

242. SIGNATURE OF SHERIFF

243. SIGNATURE OF CORONER

244. SIGNATURE OF DECEASED

245. SIGNATURE OF WITNESS

246. SIGNATURE OF PHYSICIAN

247. SIGNATURE OF CLERK

248. SIGNATURE OF JUDGE

249. SIGNATURE OF SHERIFF

250. SIGNATURE OF CORONER

251. SIGNATURE OF DECEASED

252. SIGNATURE OF WITNESS

253. SIGNATURE OF PHYSICIAN

254. SIGNATURE OF CLERK

255. SIGNATURE OF JUDGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09044 355

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Worcester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Whaleyville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x2 Whaleyville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>xxx</b>		d. STREET ADDRESS <b>1 xxx</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Edward</b> Last <b>Tingle</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>16</b> Year <b>19 57</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 16, 1880</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>11</b> Days <b>17</b> Hours <b>19</b> Min.	IF UNDER 24 HRS. Months <b>11</b> Days <b>17</b> Hours <b>19</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Auto</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Tingle</b>		14. MOTHER'S MAIDEN NAME <b>Angeline Brevard</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>0</b>		16. SOCIAL SECURITY NO. <b>910-219-03-6771</b>	
17. INFORMANT <b>Jennie Tingle</b>		Address <b>Whaleyville Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> DUE TO <b>002X</b> Conditions, if any, which gave rise to immediate cause (b) <b>Congestive Heart Failure</b> DUE TO <b>Chronic Pulmonary Tuberculosis</b> lying cause lost. (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>2 days</b> <b>1 yr</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8/24</b> , 19 <b>56</b> , to <b>8/15</b> , 19 <b>57</b> , that I last saw the deceased alive on <b>8-15</b> , 19 <b>57</b> , and that death occurred at <b>8:00 P</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ivory U. Sully, Jr.</b> M.D.		ADDRESS (Street, city or town, state) <b>Berlin, Md</b>	
PHYSICIAN'S NAME (Type) <b>Ivory U. Sully, Jr., MD</b>		DATE SIGNED <b>8/16/57</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-18-57</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Pulletts Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Whaleyville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Peter Whaley Whaleyville, Del.</b>		24a. REC'D BY REGISTRAR <b>AUG 20 1957</b>	
ADDRESS <b>Whaleyville, Del.</b>		24b. REGISTRAR'S SIGNATURE <b>John Hayward</b>	



9035

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>WORCESTER</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>WORCESTER</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>		c. LENGTH OF STAY IN 1b <b>2 WEEKS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BERLIN</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VLADIMIR</b> First <b>WACZYK</b> Middle <b>WACZYK</b> Last				4. DATE OF DEATH Month <b>August</b> Day <b>18</b> Year <b>1957</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 1907</b>		9. AGE (In years last birthday) <b>50</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>VETERINARY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>POULTRY</b>		11. BIRTHPLACE (State or foreign country) <b>TARNOPOL POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAKOB WACZYK</b>				14. MOTHER'S MAIDEN NAME <b>JOSEFA FEDOROWYCH</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>DR. DONALD NOLL, BERLIN, MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> <b>430.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. <b>—</b> p. m. <b>—</b> 19 <b>—</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Herman A. Robbins</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>HERMAN A. Robbins</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>8/26/57</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SOUTH HILL</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE ALBERT, CANADA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Armen D. Burboye Berlin Md</b>				24a. REC'D BY REGISTRAR <b>AUG 22 1957</b>		24b. REGISTRAR'S SIGNATURE <b>Robert Hayward</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

AUG 22 1957

BUREAU V. R.